ACCT# ________
BP: ________
Ht: ________
Wt: ________

Please circle the provider you are here to see:

DEISHER FALKENSTROM FREEMAN HULKER MORGAN PATTERSON STRAUGHN

LAST NAME: ________________________FIRST NAME: ____________________DOB: ____________

Marital Status: S M D W O Patient's Employer: ___________________Position: _____________

Pharmacy Name & Address: ____

Circle the purpose of your visit: ANNUAL PROBLEM POSTPARTUM POSTOP OTHER

What problems or concerns would you like to discuss today? ________________________________
____

Are you allergic to any medications? Yes___ No__ If so, list and name reaction: _________________

Please list all the medications and dosages you are currently taking, including prescription & over the counter:

____

____

Gynecology History:

When was the FIRST day of your last menstrual cycle? _____________

Are you sexually active? Yes ___ No___ Sexual partner preference? ____________

Have you had a sexually transmitted infection? Yes ___ No __

What are you using for contraception? Birth Control Pills The Patch The Ring Depo-Provera Nexplanon IUD Condoms Pullout Natural Family Planning Tubal Vasectomy Nothing

Have you had an abnormal pap smear? Yes ___ No ____

Age of onset of first period? __________

Are your periods regular? Yes ___ No ___

Would you consider them heavy? Yes ___ No ___

Do you have pain with your periods? Yes ___ No ___

If yes, how severe is your pain? Mild ____ Moderate ___ Severe ___

Have you ever been diagnosed with endometriosis? Yes ___ No __

If you are postmenopausal, are you on hormone replacement therapy? Yes ___ No ___

Last Pap/Annual: _________Last Mammogram: _________Last Colonoscopy: _________Last Bone Scan:________

Have you ever received a dose of the HPV vaccine? Yes___ No___

Patient Signature: ______________________ Date: _____________ NGYN

Pregnancy History: (any pregnancies you have had)

Date of Delivery	How many weeks?	Birth Weight	Male or Female?	Vaginal or Cesarean Delivery?	Reason for Cesarean?	Epidural?	Place of Delivery	Complications/ Comments?

Any miscarriages/ abortions? Yes___ No ___ If yes, how many? ____________

Family History:

Relationship	Breast, Ovarian, Uterine, or Colon Cancer	Blood Clots	Diabetes	Heart Disease/ Heart Attack	Hypertension	Other
Mother						
Father						
Brother						
Sister						
Other						

Social History:

Do you exercise? If yes, how frequently? ____________________________________

Do you smoke? If yes, how much per day? __________________________________

Do you drink alcohol? If yes, how much? ____________________________________

Do you use recreational drugs? ____

Surgical History: List any surgery and the date they were performed:

____

____

Medical History: (List any medical problems such as diabetes, asthma, migraines, hypertension, depression, etc.):

____

____

Patent Signature: _______________________ Date: _____________ NGYN